MAINE
BOARD OF PHARMACY

Application information to assist in completing your application. This information is not designed to include all information on laws and rules and it is strongly recommended that you review applicable laws and rules.

Pharmacist Reinstatement

(91 days up to 2 years from Expiration)

(Reference Board Law 32 MRS §13734 (1))

Do not return the following informational pages with your application; it is for your information only

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345
Office Direct Line (207) 624-8620 or Main Receptionist (207) 624-8603
TTY users call Maine relay 711
FAX (207) 624-8637
Web address: www.maine.gov/professionallicensing
Email: pharmacy.lic@maine.gov

APPLICATION INSTRUCTIONS
PHARMACIST REINSTATEMENT

The following is a guideline to assist in your application process. It does not, however, replace the requirements outlined in the Maine Board of Pharmacy Laws and Rules. Please review them carefully for more detailed and clarifying information.

- You must provide evidence of having completed a minimum of 1,500 internship hours from a college or state licensing body.
- All Foreign pharmacy graduates must submit the FPGEC issued by NABP. You must submit the appropriate certification evidence issued by NABP with this application. Please visit the NABP website for information on the FPGEE process and to contact NABP http:// www.nabp.net/ . We cannot help you on this matter.
- Official transcripts of your pharmacy degree must accompany your application.
- You must demonstrate that you are at least 21 years of age. A copy of your official birth certificate or other official legal document is acceptable.
- If you hold or have held a pharmaceutical license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.
- Not all pages of this application contain your name, please place your initials on pages where noted.

The Board may waive the Naplex and the Multi-State Pharmacy Jurisprudence Exam. Below is the information in the event you are required to re-test for either examination.

- To register for the NAPLEX and the Multi-State Pharmacy Jurisprudence Examination, go to http://www.nabp.net/. Please note if you are applying by score transfer, the score is valid for one year only from date of passing NAPLEX examination.
- Your NAPLEX, Score Transfer and MPJE score results are reported directly by electronic means to the Maine Board, which in turn will be reported to you in writing. **Please allow at least 10 business days**. Please do not call our office for your results. Scores will not be released by phone.
- If you have a disability and require special accommodations in taking the examination, please complete the enclosed "request for accommodation" form and submit it with your application. The Maine Board of Pharmacy outsources all examination administrations. Special accommodation request must be submitted well in advance of the test date, we cannot guarantee the availability of accommodations on-site.
- MULTISTATE PHARMACY JURISPRUDENCE EXAM (“MPJE™”) References: The Maine Pharmacy laws and rules, Department of Public Safety rules on security prescription blanks, and pharmacy related federal regulations are accessible online at www.maine.gov/ professionallicensing Click on “list of licensed professionals", click on “Pharmacy” under “Board of Pharmacy Home” click on “Laws & Rules” You may also contact the following agency for federal regulations: U.S. Government Printing Office Tel (202) 512-1800, at the following web site: www.access.gpo.gov/nara/cfr/cfr-table-search.html

INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED. Be sure to initial the bottom of each page where noted on your application. This is critical to insuring that each page of your application is intact with the correlating application and will help us with expediting your application review. All pages requiring initials must be returned to our office as part of your complete application.

The Maine Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered (including the use of any white out substance) in any way will not be accepted.

PROCESSING TIME:

- ✓ Your application has greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending or under review. Once reviewed and if everything about your application is complete and complies with requirements, the authority to administer will be issued and the status will show as ACTIVE. If incomplete and a letter is being sent to you, the letter will be available for you to see online.

- ✓ Please refrain from calling our office to "check" on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

- ✓ Once your license is issued it is immediately visible online with an "active" status. Licenses are printed off site and require at least 14 business days for delivery.

VERIFICATION OF LICENSURE

If you hold or have held a professional license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.

Please contact the state of licensure to request an official License Verification. At a minimum, the license verification must contain:

- Name of State providing the License Verification
- Your name
- License number and expiration date
- Status of your license i.e. active, inactive, lapsed, probation, restricted, suspended, revoked…
- Type of license issued to you
- Date your license was issued
- If appropriate, hours of internship completed with beginning and ending dates
- Method your license was issued i.e. Original State, Reciprocity/Endorsement, Score Transfer
- Examinations taken i.e. NAPLEX, Jurisprudence, other
- Disciplinary action(s) against your license, if any
- Signature and title of person from the licensing jurisdiction providing License Verification
- State Seal

Please direct the licensing jurisdiction to send the License Verification report to you directly and in turn you must submit this verification with your completed Maine application.

A sample license verification is available on the Board's website in the applications and forms section.

IMPORTANT: Applications submitted without **all of the Verifications of Licensure** from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

You may also obtain an electronically produced License Verification directly from the State Board website. For electronic License Verifications please be sure that it contains the State web-address and date the License Verification was printed.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address**: 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974. Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 36 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(c)(2)(C)(i)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) *or* credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
INDIVIDUAL LICENSE APPLICATION

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME	*FIRST*	*MIDDLE INITIAL*	*LAST*
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH *mm / dd / yyyy*		SOCIAL SECURITY NUMBER - -	
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )	FAX # ( )	E-MAIL	

CRIMINAL BACKGROUND DISCLOSURE

NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

1. **Have you ever been convicted by any court of any crime?**
   (circle one) NO YES
   If yes, enclose a signed detailed description of what happened (including dates) and a copy of the court judgment.
2. **Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one) NO YES**
   If yes, enclose a signed detailed explanation and copies of all documents.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE **DATE**

MAINE BOARD OF PHARMACY
Pharmacist Reinstatement
Required Fees - $146.00 (Non Refundable)

(includes license, late fee and criminal records check fees)

FOR LICENSES THAT HAVE EXPIRED 91 DAYS UP TO 2 YEARS FROM THE DATE OF EXPIRATION.

Optional Certification of Administration of Drugs and Vaccines Available

License Number: _____

Date License Expired: _____

Office Use Only:

PR 1421 - $75.00
2619 - $21.00
2090 - $50.00

Office Use Only:

Check #_____
Amount:_____
Cash #_____
Lic. #_____
Issue Date_____
Exp. Date_____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*

I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my ☐ VISA ☐ MASTERCARD the following amount: $_____

☐ **I understand that fees are non-refundable**

Card number: *XXXX-XXXX-XXXX-XXXX* Expiration Date *mm / yyyy*

SIGNATURE **DATE**

SECTION 1: INTERNSHIP

You must submit evidence of having completed 1,500 hours of internship training.
☐ Evidence from the college where I completed a pharmacy degree program.
☐ Signed affidavit(s) from Preceptor(s).
☐ Certification by a state pharmacy licensing board where these hours were reported.

SECTION 2: EDUCATION

Please check all that apply:
☐ American Council on Pharmaceutical Education (ACPE)
☐ Canadian Council for Accreditation of Pharmacy Programs (CCAP)
☐ Foreign Pharmacy Graduate
☐ FPGEC

College of Pharmacy		Date of Graduation
Contact Address	PO BOX or Street Address	
City	State	Zip
Official transcripts demonstrating your degree must be submitted with your application.		

_____ INITIALS OF APPLICANT

SECTION 3: LIST BELOW EVERY JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PROFESSIONAL LICENSE. Includes pharmacy technician, pharmacy intern, pharmacist or any other professional license or registration. List each state in which you hold or have ever held a pharmacy technician, pharmacist or pharmacy intern license or registration.

1. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
4. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date

Use a separate sheet of paper if additional space is needed.

NOTE: For each of the above, you must submit with this application an official Verification of Licensure from **each** licensing jurisdiction. **IMPORTANT:** Applications submitted without **all of the Verifications of Licensure** from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

SECTION 4: Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

Have you ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or have you ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances? If yes: 1. □ DEA action □ Other State of Province (Name) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper.	□ Yes □ No
Have you ever received a sanction from Medicare or from a state Medicaid program? 1. □ Medicare OR □ Medicaid Program (State) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper. Clarification on programs: • Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease. • Medicaid – Health program administered by the United States government for people with limited incomes. • MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.	□ Yes □ No

_____ INITIALS OF APPLICANT

SECTION 5: CERTIFICATE OF ADMINISTRATION OF DRUGS AND VACCINES
YOU MUST COMPLETE SECTION A, B OR C, WHICHEVER APPLIES.
☐ Check if you're seeking reinstatement of licen- ☐ sure

SECTION A: Currently authorized by another jurisdiction to administer drugs and vaccines and your training or course work is compliant with 32 MRSA § 13832(4). (See insert in gray section below).

Are you currently authorized/licensed by any jurisdiction to administer drugs and vaccines?
☐ Yes or ☐ No List State:_____.

Do you have continous administration practice since completion of training in drug administration? (32 MRSA § 13832(4)) ☐ Yes or ☐ No

Has any adverse disciplinary action been taken against this authorization/license? ☐ Yes or ☐ No

Please submit a license verification from the licensing jurisdiction to verify that you are authorized to administer drugs and vaccines.

If you are not currently certified/licensed in another jurisdiction and qualify with educational licensing, please complete section B or C, whichever applies.

For Section B or C

Your PharmD transcripts or evidence of having completed a 20 hour course of study **must** accompany this application; otherwise your application will be deemed incomplete and returned without processing. The PharmD program or the 20 hour course of study must meet the didactic & practical requirements described in 32 MRSA § 13832(4).

32 MRSA § 13832(4)
Didactic; practical course. Satisfactorily complete a didactic and practical course approved by the board that includes the current guidelines and recommendations of the federal Department of Health and Human Services, Centers for Disease Control and Prevention, the American Council on Pharmaceutical Education or a similar health authority or professional body, and that includes, but is not limited to, disease epidemiology, indications for use of vaccines, vaccine characteristics, injection techniques, adverse reactions to vaccines, emergency response to adverse events, immunization screening, informed consent, record keeping, registries, including the immunization information system established under Title 22, section 1064, registry training and reporting mechanisms, including reporting adverse events, life support training, biohazard waste disposal and sterile techniques and related topics.

Pursuant to 32 MRSA Sub-Section 13832(3) training must have been obtained within 3 years immediately preceding this application. In addition:
- A PharmD transcript must clearly state your name and date the degree was awarded.
- The 20 hour course of study must clearly state your name, date of completion and the number of hours completed.

SECTION B: TRAINING - Complete this section IF APPLYING BY HAVING COMPLETED A 20-HOUR COURSE OF STUDY (32 MRSA §13832, section 3)

Please list the name of the course, the course sponsor and date course completed.

□ Check here if this is an *American Council on Pharmaceutical Education (ACPE)* course.

Course name:_____

Date Completed:_____

□ Check here if this is a course sponsored or approved by the *Centers for Disease Control and Prevention*.

Course name:_____

Date Completed:_____

□ Check here if *Other*: - please provide a copy of the course syllabus or course content.
Course sponsor:_____

Course name:_____

Date Completed:_____

_____ INITIALS OF APPLICANT

SECTION 6: NOTICES

Please Note:

Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days.

You can access this Law for your review at:
http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html

SECTION 7: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application. Applications that are incomplete, altered (including use of any white out), defaced, or compromised will not be accepted and will be returned. This includes, but is not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing required supporting documents, and/or missing or wrong fee.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

The Applicant certifies by his/her signature that the management of the pharmacy will be vested with the licensed pharmacist in all matters directly or indirectly related to the practice of pharmacy or in any matters related to health, welfare, and safety of the public, as required by 32 MRS Section 13752(4).

Applications that are incomplete, altered (including the use of any white out substance), defaced, or compromised will not be accepted and will be returned. This includes, but not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing supporting documents, and/or missing or wrong fee.

Printed Name of Applicant	Title
Signature of Applicant	Date
	

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
MAINE BOARD OF PHARMACY
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
TEL:(207)624-8620 – FAX:(207)624-8637

AFFIDAVIT OF INTERNSHIP HOURS

****This form is only to be used if your state does not certify intern hours obtained****

Last Name	First Name	Middle Name

Contact Address (Street or PO Box)		
City	State	Zip Code

Intern License Number	State Issued	Expiration Date

Place of Internship - Name of Facility	License Number

Physical Address		
City	State	Zip Code

Telephone Number
( )

Preceptor Name	License Number

Hours worked at this site (give only exact dates that this report covers – **not entire work history**)

Beginning Date of this Report	End Date of this Report	Total number of hours worked at this site during the period stated.

The above information was taken from payroll or other records which are kept at the following location(s) and may be examined by an agent of the Board (Give Street Address, City, and State): _____

_____

I hereby state that the intern named above was trained at the site listed above, worked the hours reported, and practiced in accordance with the Board's Laws and Rules. I further understand that I shall be responsible for certifying the practical experience affidavits required by the Maine Board of Pharmacy and submit reports on the progress and aptitude of the intern when requested. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

_____

Affirmation and Signature of Preceptor Date State and License #

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AUGUSTA, MAINE 04333-0035
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CERTIFICATE OF MORAL CHARACTER

This form must be completed by the person attesting to the applicant's good moral, ethical and professional character.

The person attesting to the applicant's good moral character must personally know him/her and be prepared to furnish additional information concerning the applicant's character, education, and standing as may be requested by the Board of Pharmacy.

I, the undersigned, hereby affirm that I am personally acquainted with the applicant named below and know him/her to be of good moral character.

Please write legibly.

Applicant's Name *(Please Print)*		
Name of Person Conferring Applicant's Character	Name	
	Street	
	City/State/Zip	
	Telephone #	Email Address:
	Occupation	Date
	Signature	
Briefly describe how the applicant is known to you. (e.g. fellow colleague, neighbor, long time friend, etc.)		

By submitting this application and supporting documents I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

_____

SIGNATURE OF APPLICANT DATE

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
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MAINE BOARD OF PHARMACY
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
TEL:(207)624-8603 – FAX:(207)624-8637

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

NAME: _____

ADDRESS: _____

TELEPHONE #: _____ SOCIAL SECURITY NUMBER: _____

Accommodations Requested for the _____ Examination.
Disability _____

Please check all that apply

☐ Accessible Testing Site
☐ Separate Testing Site
☐ Braille
☐ Large Print
☐ Tape
☐ Reader as Accommodation for Visual Impairment
☐ Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
☐ Reader as Accommodation for Learning Disability
☐ Scribe/Amanuensis as Accommodation for Learning
☐ Sign Language Interpreter
☐ Extended Time
  ☐ Time-and-a-half
  ☐ Double time
  ☐ More than double time (specify): _____
☐ Use of Computer or other adaptive equipment (specify): _____
☐ Other:_____

_____

Signed:_____ Date: _____

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DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ **since** _____ **in**
(Test applicant) (Date)

my capacity as a _____.
(Professional Title)

This applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, providing the following should accommodate him/ her: (check all that apply):

☐ Accessible Testing Site
☐ Separate Testing Site
☐ Braille
☐ Large Print
☐ Tape
☐ Reader as Accommodation for Visual Impairment
☐ Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
☐ Reader as Accommodation for Learning Disability
☐ Scribe/Amanuensis as Accommodation for Learning
☐ Sign Language Interpreter
☐ Extended Time
  ☐ Time-and-a-half
  ☐ Double time
  ☐ More than double time (specify): _____
☐ Use of Computer or other adaptive equipment (specify): _____
☐ Other:_____

Signed: _____ Title: _____

Date: _____ License # (if applicable): _____